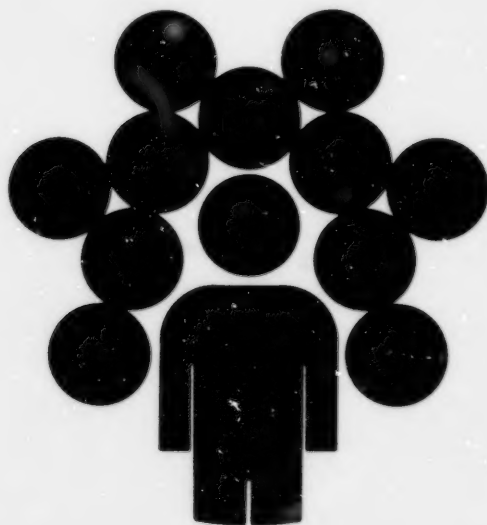
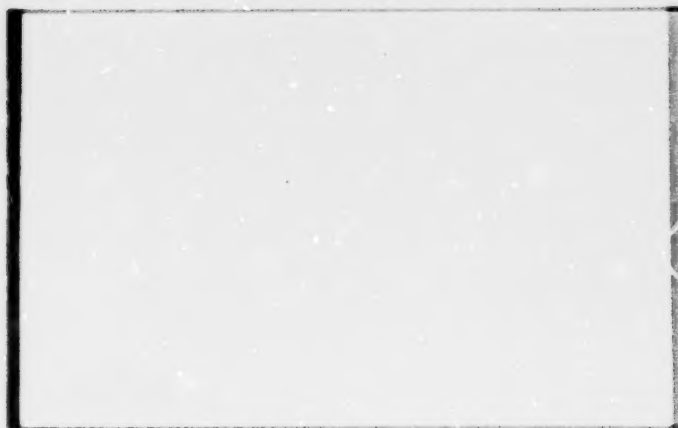


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**Health and Welfare
Canada**

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Canada**

CHRONIC MENTAL DISORDERS

IN

CANADA

A Needs Assessment Project prepared for the
Canadian Mental Health Association¹

and

Report of a National Symposium convened by the
Canadian Mental Health Association²

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P R E F A C E

CHRONIC MENTAL DISORDERS IN CANADA: A NEEDS ASSESSMENT PROJECT is the report of the Mental Health Services Committee of the Canadian Mental Health Association. Representing two years of work of Committee members and their provincial associates, this report includes four distinct components: 1) a position paper reviewing the history of the problems, the role of the Canadian Mental Health Association, and the growing concerns which led up to the establishment of this Committee; 2) a survey of informed and expert opinion of both the professional and lay staff directly responsible for patient care; 3) the results of professional consultations with provincial mental health association members; and 4) a summary of the proceedings of a national meeting of professionals involved in the care of the chronically mentally ill.

The purpose of this four-fold effort was to document the status of mental health services for the chronically mentally ill in Canada. A major objective was to provide some cohesive structure for the expressions of concern which were being raised in all areas of the country, and to assess whether there was, indeed, some consistency and some core area of consensus on which to build a national action program. The action program which evolved from these activities is reflected in the Recommendations contained in Section V. The Mental Health Division of Health and Welfare Canada is publishing this Report for wider distribution in support of these recommendations and in the belief that the document will be of interest to various levels of government and to members of the lay and professional public.

In considering the findings of this project, it should be remembered that the sample in this study was not a random sample and cannot be considered to be representative of mental health professionals in Canada as a whole. In this regard, the aim was to obtain the views of people knowledgeable of the

mental health delivery system. The material as a whole can then be considered to represent a valuable interpretation of the present level of concern among the mental health constituencies associated with the Canadian Mental Health Association.

The Mental Health Services Committee is particularly indebted to Dr. John Toews and Dr. Gordon Barnes who are the authors of the report.

The report has been edited and published on behalf of the Canadian Mental Health Association by the Mental Health Division, Health Services and Promotion Branch, Health and Welfare Canada.

Additional copies may be received from: National Office,
Canadian Mental Health
Association,
2160 Yonge Street,
TORONTO, Ontario.

Two supplementary documents are also available from the CMHA National Office for those who wish to study this issue in more detail:

Tables and Figures from the Key Informant Survey,
Annotated Bibliography

EXECUTIVE SUMMARY

CHRONIC MENTAL DISORDERS IN CANADA: A NEEDS ASSESSMENT PROJECT

Canada, like other Western countries, has undergone a major shift in the provision of mental health services to people with chronic mental disorders. The mental institutions have been downgraded as the cornerstone of the mental health care system in favour of community and general hospital treatment of people with these disorders. The concept of community care has been eagerly supported by most. However, over the last five to ten years, increasing concern has been raised about the fate of the now deinstitutionalized patient in the community. There are reports of inadequate housing, life skills, activity and work preparation programs. The staff working the community programs are reported to be overloaded with clients and to be extremely frustrated by the lack of resources. People with longer term mental disorders are decompensating in the community, the psychiatric units in general hospitals are becoming too full to do more than brief and often cursory care and the mental hospitals, which over the years have had a reduction of two thirds of their beds, can no longer accept the longer term patient as they did in the past.

Many people within CMHA raised concerns about what was happening to the chronically mentally ill in Canada. In response to these concerns, the CMHA undertook to sponsor a national study on the care of the people with longer term mental disorders in Canada. This study was completed in 1982.

The study has four components:

1. A needs assessment survey of 222 mental health professionals regarding their opinions of the service system for the chronically mentally ill in their provinces. (Dr. Barnes has prepared a separate summary of the results in this survey).

2. Provincial forums in which people who had been invited to respond to the needs assessment survey were asked to amplify on their responses and discuss in a general way the strengths and weaknesses of the service system of their provinces.
3. A national forum where people from across the country met to discuss in detail the issues faced in Canada by the process of deinstitutionalization. This forum was funded by a grant from the federal government through the Mental Health Division.
4. A selective annotated bibliography of over 400 references from the professional literature on the service system for people with chronic mental disorders. This bibliography is now completed and will be published and made available to the various CMHA Divisions and Branches pending funding for publication.

MAJOR FINDINGS OF THE PROJECT

The major finds of the study are as follows:

1. The service system for the care of the chronically mentally ill in Canada is severely overloaded and mental health practitioners are having difficulty managing the number of patients looking to them for help.
2. The trend towards deinstitutionalization appears to be continuing without the assurance of adequate community support for those already in the community. As well, a new group of patients who have not previously been in the large mental institutions, now require supportive services in the community to lessen the extent of the revolving door syndrome (ie. repetitive admissions and discharges from the general hospitals).

3. Specifically, major concern has been raised about:

- a) insufficient numbers of spaces and insufficient range of housing. Even in supervised residences, those in charge often lack the knowledge and training necessary to help their residents as required.
 - b) insufficient social rehabilitative programs and vocational programs. It was recognized by the participants that a goal of full paid employment of the clients was often unrealistic and that more long term programs for the care of this population must be structured in such a way as to provide lifetime care if necessary.
 - c) insufficient financial resources to allow for some participation in normal life activities by the clients. This varied to some extent between provinces.
 - d) insufficient development and use of programs that serve as alternatives to full hospitalization.
4. These deficits in the service system as well as actual gaps in the availability of services were seen to affect adversely the client's adjustment and placed an over dependence on the already over crowded hospitals or promoted abandonment of clients in the community without adequate resources.
5. From the overall perspective of the service system there was widespread concern that:
- a) Community aspects of the services to the chronically mentally ill were grossly underfunded.

- b) Often there are no clearly recognized lines of responsibility for the whole range of services required.
- c) Often services are provided in the absence of a fully recognized plan that demands the coordination of services and the responsibility for the development of these services.

6. Stigma was seen as operating at:

- a) the societal level where it promotes the ghettoization of the chronically mentally ill.
- b) the professional level where professional prestige and rewards seem to be attached to the treatment of the other groups of clients as opposed to the work done with this particular group.
- c) the level of the services where often the attitude is paternalistic rather than one of negotiation and collaboration with the client.

7. Respondents felt the need for programs designed to train professionals to deal specifically with the chronic mental disorders. Most professional schools do not emphasize the care of those who suffer from the severe mental disorders.

8. Research into the biological, psychological and social underpinnings of chronicity is required as well as into the process of service delivery to this population.

A participant at the national forum paraphrased L. Bacharach's list of the characteristics of successful services for this group of people. They are:

1. the chronically mentally ill must be targeted as top priority in care as they do not fare well in programs where there are less impaired clients absorbing staff time;
2. there must be linkage with other resources;
3. there must be a full range of services to supplement services that were traditionally carried out in hospital settings;
4. treatment must be tailored individually. A case management model and a 24 hour crisis intervention service are essential;
5. the services must be culturally relevant and specific;
6. staff must be specifically trained in the care of the chronically mentally ill;
7. there must be a readily available hospital liaison;
8. there must be internal service evaluation.

RECOMMENDATIONS

Many different recommendations were made concerning the specific aspects of the services for the chronically mentally ill. The authors of the report felt that in keeping with the role of CMHA in its concern for the plight of those with longer term mental disorders, that the following recommendations should be made to the Association:

1. The Canadian Mental Health Association should intensify its historically strong advocacy stance at the National, Divisional and Branch levels for services for this population. This stance should include:

- a) lobbying the various levels of governments;
- b) public education; and
- c) volunteer programs

Lobbying is required to increase the sensitivity of our elected representatives to these needs. Public education is required to sensitize the community to the needs of the chronically mentally ill and to aid in decreasing the stigma associated with this disability. Volunteer programs aid greatly in fostering community involvement in the problems and in decreasing the stigma associated with these disorders.

- 2. The CMHA should assist its Divisions in preparing specific strategies for documenting further specific needs and perspectives on the care of the longer term mentally ill on a regional (Divisional) basis.
- 3. A specific survey of the clients' and friends' and relatives' perspectives on care should be undertaken to balance and complement this particular professionally based study.
- 4. A study should be undertaken to document specific mental health service needs in the Northern and remote areas of Canada.
- 5. CMHA should help in the development and testing of model administrative structures and model programs for the chronically mentally ill.
- 6. The development of professional educational courses on the care of the chronically mentally ill should be promoted.
- 7. CMHA should maintain a stance in support of additional basic and applied research into these disorders.

1. Introduction: Services for the Chronically Mentally Ill in Canada

The mental health service system in Canada has changed dramatically over the last two decades from a largely institutional base for the care of the chronically mentally ill to a reliance on community resources and the general hospital for provision of that care. The process by which the chronically mentally ill were shifted from the institution to the community (deinstitutionalization) was widely supported by those concerned about the deleterious and dehumanizing effects of the large institutions (cf. Test & Stein, 1978). They noted that once dependence on the institution was formed, it was very difficult for the longer term mentally ill to live in the community. It was hoped that this new approach to maintaining those with chronic mental disorders in the community would provide a benevolent noninstitutional milieu in which to live. This milieu would include adequate housing, social-rehabilitative programming, employment opportunities and the potential to bring each person to his/her optimum level of functioning. The general hospital was to serve as a back-up to the community, so that the mentally ill could continue in close relationship to their families and social environment even when hospitalized and so that outpatient follow-up and partial hospitalization could work together to provide maximum time in the community for the people with the more chronic disorders.

That deinstitutionalization has occurred is evident. There has been a reduction of approximately two-thirds of the mental hospital beds from the peak bed numbers (STATS Canada, 1978-79). The remaining beds are used for those who are too impaired to be discharged and to provide space for brief admissions. General hospital psychiatric beds have not yet replaced mental hospital beds in adequate numbers. Both the general hospital wards and the mental hospital are full and there is a rapid and futile turnover of patients so that people are admitted, treated briefly, sent back to cope in the community. However, it has been reported that the case loads of community mental health workers have been strained to capacity and that now often only perfunctory and emergency care is available (e.g., Marshal, 1982). It has also been reported that there are gross deficiencies in the numbers of spaces for patients in programs that aim at a social rehabilitation model and that

there is often inadequate housing and certainly a paucity of supervised housing available to the chronically mentally ill (e.g., Supportive Housing Coalition, 1981). And so, the classical revolving door keeps revolving with many needless readmissions brought about by the failure of adequate community resources.

How many chronically mentally ill are there in Canada? There are no clear figures. However, extrapolating from U.S. figures where it is estimated that approximately 1% of the population is receiving care for a chronic mental disorder in a supervised setting (Goldman, 1981) we can assume that in Canada approximately 200,000 people exist in need of mental health services designed to minimize the problem and promote an optimum level of functioning. Of these, it is estimated that approximately one-third are people with severe schizophrenic disorders, one-third suffer from organic mental conditions and one-third have other diagnoses. Dr. Roger Bland (1982), utilizing Statistics Canada figures for people with various diagnoses and utilizing outcome studies to determine the percentage of people with poor outcomes suggest that in Canada approximately 60,000 people with a diagnosis of schizophrenia have unfavourable or very unfavourable outcomes. If we assume that this group is one-third of the population with chronic mental disorders, we arrive at a total of approximately 180,000 people in need of supportive services as a result of a chronic mental disorder. So, in arriving at the figure of 180,000 to 200,000 in two different ways we can be relatively confident that there are at least that many seriously mentally disadvantaged in our population. This may well be a conservative figure since it only includes those who are severely disabled and does not include all the others who also require the mental health care system for some help with their problems.

By all reports the mental health care system is grossly overloaded and the chronically mentally ill, now existing in the community, are in desperate straits. With the change in the locus of care from the institution to the community the needs of this population have changed as well. Now housing,

noninstitutional activity programs, employment preparation programs, social recreation programs and various general hospital and psychiatry follow-up services are required. As well, if people with these problems are residing within the community, both support for the family and financial support are required. Discrimination, stigma and neglect will adversely affect the realization of any of the goals that might hope to maximize the development of the individual's potential to enjoy as full and rewarding a future as possible.

Early in the process of deinstitutionalization the Canadian Mental Health Association through its various divisions and branches advocated the provision of the community supports and programs necessary to provide care for the more chronically mentally ill in the community. As the process of deinstitutionalization progressed and the programs did not appear in sufficient numbers and as the closure of institutional beds continued, despite the already apparent inadequacy of community supports for this population and as the plight of many of those in the community became generally known, the Canadian Mental Health Association determined that once again it must vigorously defend the rights of the mentally ill to treatment. This was certainly in keeping with the earlier roles of the association when, at its inception, it championed the cause of the mentally ill within the institutions, and for many served as the humane and caring bridge between the community and the institutions. With the formation of the general hospital psychiatric units in the 1950's and 60's the Canadian Mental Health Association again expressed its concerns for the care of the mentally ill, producing the now classic report, More for the Mind - a report that still serves as a blueprint for the care of the mentally ill within a community and general hospital system.

The current concern for the plight of the chronically mentally ill arose from the divisions and branches of the Canadian Mental Health Association during the mid 1970's as it was noted at the local and provincial levels that the services for the mentally ill were inadequate, that needs were not being met and, what is more, the resources did not seem to exist to remedy the situation.

In 1978 a paper that was initially a discussion paper for the Canadian Mental Health Association entitled "Mental Health Services in a Time of Restraint" (Toews, 1980) provided a focus for much of the concern that had been expressed. The central theme of this paper was that we are caught between an inadequate and antiquated mental hospital system, a general hospital system poorly equipped to deal with the specific needs of the chronically mentally ill, and a community care system that is overloaded and as yet lacks the resources to deal adequately with the problems presented by the chronically mentally ill. What is more, the economic difficulties that have been in existence since the mid 1970's have made it unlikely that more money will be readily available to help the chronically mentally ill. Unless we are vigilant, people with these disorders will be abandoned in the community to fend for themselves. Reports now appearing, for example the concern of the ghettoization of the Parkdale area of Toronto or the report, Madness: An Indictment of the Mental Health Care System in Ontario (Marshall, 1982), or the numerous reports generated by this Canadian Mental Health Association project give credence to these concerns.

Clearly, there is a need to document the status of our mental health services for the chronically mentally ill in preparation for a strong advocacy stance. Annual surveys of Canadian Mental Health Association divisions while confirming the observations of the original discussion paper did not present data in such a way that a synthetic picture of a national scope could emerge. The Canadian Mental Health Association therefore, in keeping with the importance it attaches to the advocacy for adequate care and support for the chronically mentally ill, established a Mental Health Services Committee with the funding and the mandate to devise a method of conducting a national needs assessment. The committee was formed in the spring of 1981 and has devised and supervised the development and administration of the needs assessment (committee composition - Appendix 1).

The Needs Assessment Project

The Mental Health Services Committee conceptualized the needs assessment project as having four distinct though complimentary components. First, a needs survey that could be administered at the provincial or divisional level with standardized reporting mechanisms was devised. Second, provincial consultations in each division for the respondents to the needs survey was planned. The purpose of these meetings was to allow the respondents to amplify their responses to the questions in the survey, provide examples and, to prioritize and make known their concerns related to the mental health care system for the chronically mentally ill in their province. Third, a national symposium on perspectives on the care of the longer term mentally ill in Canada was proposed. This meeting, sponsored by the Canadian Mental Health Association with a grant from the Mental Health Division of the Federal Government, allowed 30 professionals involved in the care of the chronically mentally ill to meet for approximately two days to compare perspectives and to make recommendations concerning priorities within the mental health care system for this population. Fourth, a review of the literature and an annotated bibliography was proposed. It is expected that this bibliography will contain approximately 400 references from the English literature on the chronically mentally ill of the last ten years when finally compiled. The bibliography is being produced so that there can be ready access to the relevant material in the literature to support whatever recommendations are required in order to improve the services for the longer term mentally ill.

It is hoped that with a truly national picture the Canadian Mental Health Association can effectively represent to the Federal Government the needs of the chronically mentally ill at the same time that it facilitates the involvement of the Canadian Mental Health Association divisions in their own documentation of service needs and in representations to their provincial governments and other funding bodies.

This report will deal with the needs survey, the community forums, and the national symposium on perspectives on the care of the longer term mentally ill. The annotated bibliography will be made available when it is completed.

II. Method

A. Needs Assessment Strategies

The process of needs assessment has been defined (Milord, 1976) as "an attempt at identifying and defining the most pressing needs of a given geosocial area" (p. 260). Traditionally needs have been assessed through an epidemiological strategy (Milord, 1976). Using this strategy to assess the needs of chronic mental patients would require an extensive general population survey to identify the percentage of the population suffering from chronic mental disorders, and the requirements for service within this group. While this approach has some obvious advantages in terms of its comprehensibility etc., it also suffers from the major drawback of being extremely expensive. Alternative strategies of human service needs assessment have been gaining in popularity in recent years. Some of these strategies for assessing human service needs have been described in a review paper by Milord (1976). These strategies include; the use of social indicators, the use of community forums, holding workshops and surveying key informants. A key ingredient in any needs assessment strategy seems to be the utilization of a combination of techniques allowing a cross checking of data obtained through different data collection strategies.

B. Assessing the Needs of Canadian Chronic Mental Patients

Aside from conducting a general population survey, there are several possible strategies available for assessing the service needs of chronic mental patients. One of these strategies would be to obtain social indicator data from each province in Canada. Data would be required on the number of chronic patients in each province, the number of inpatient beds available, the number of community residence beds available, the number of sheltered workshop positions required, the number of sheltered workshop positions available etc. Unfortunately the social indicators available in this field vary greatly from province to province.

While it may be possible to use social indicators to assess needs in the province of Saskatchewan for instance, this strategy could not be employed successfully on a national level. The alternative strategy which we selected for use in this project was to use a combination of strategies including; 1) a national symposium on the needs of the chronic mental patient, 2) a formal mail out survey of key informants, and 3) community forums to be held in each province. Through this combination of techniques it was hoped that a national picture of the needs of chronic mental patients would emerge. Since this strategy did not include any provision for the sampling of views of people actually using the service system, it was hoped that the next logical phase in this process would include a sampling of these views. The specific methods employed in each of these approaches is outlined below.

1. National Symposium

As a result of the interest in the Canadian Mental Health Association in assessing the service requirements of the longer term ill, a request was made of the Mental Health Division of Health and Welfare Canada to fund a national symposium on this topic. Funding was obtained and the event was held to bring together key professionals in the mental health field who had important and unique perspectives on the care of the longer term mentally ill. The expressed purpose of this meeting was to determine "where we are now in the provision of care and to suggest possible next steps in research, service design, public education, social action, etc." Each participant in this workshop was to prepare a brief introductory statement indicating their views on this problem. The overall group of 30 participants was divided into two discussion groups where ideas were initially presented and discussed. On the final day the two groups came together and an attempt was made to synthesize the views presented in the discussion session. A list of participants at the symposium is provided in Appendix 2 of this report.

2. Key Informant Surveys

The second needs assessment strategy employed in this project involved a mail out survey to be sent to approximately 25 to 30 key informants in each province. Key informants to be included in this survey were to be determined by the local Canadian Mental Health Association office. The main requirement for inclusion in this study was that the person be knowledgeable in the field of mental health and in the care of the chronically mentally ill. People were to be invited to participate who represented the following disciplines and perspectives:

- 1) government planning for mental health services,
- 2) general hospital services,
- 3) mental hospital services,
- 4) community care programs,
- 5) housing,
- 6) teaching and/or research,
- 7) rural care programs.

It was suggested that at least four representatives should be selected from each of the following four mental health professions: 1) nursing, 2) psychiatry, 3) psychology, and 4) social work.

A total of 300 questionnaires were printed and 30 of these questionnaires were sent to each province. Each Canadian Mental Health Association division was then expected to mail out its questionnaires to key informants along with a letter inviting each participant to appear at a community forum to be held in their province. At that time completed questionnaires were to be handed in. Respondents were not required to write their names on questionnaires. For those who did not appear at the community

forums follow-up letters and phone calls were to be made by the local Canadian Mental Health Association offices in an attempt to further increase the sample size. To date a total of 222 surveys have been received. Since not all of the 300 surveys were mailed out, the approximate participation rate for this part of the project is estimated to be $\frac{222}{275} = 80\%$. The sample characteristics described in

the results section indicate that we were in fact fairly successful in obtaining a wide range of mental health professionals. Results on the knowledge questionnaire also indicate that people who were selected by the local Canadian Mental Health Association divisions were in fact knowledgeable in this area.

A copy of the questionnaire used in the key informant survey is provided in Appendix 3. The following strategy was employed in developing this questionnaire. First, the academic literature on the needs of chronic mental patients was scanned. A med-line computerized bibliography turned up several hundred articles of which approximately one hundred were directly relevant to this topic. Next, brainstorming sessions were held by the authors discussing different topics presented in the literature that should be included in this survey. A description of the major topics which were determined via this process for inclusion in the survey, and the rationale for their inclusion follows:

1. Satisfaction with Current Health Services for the Chronically Mentally Ill

A wide range of services are required for the care of those with chronic mental health problems. These resources range from those which tend to be hospital based, like inpatient treatment in either mental or general hospitals, to those which

are purely community in scope, such as housing and financial support. The service system may be well developed in certain areas while being very poorly developed in others. The survey sought to determine the areas in which respondents felt services were most or least available. The services which are available may be of variable quality. Consequently, the survey attempted to determine whether the quality of specific service areas was satisfactory. Specific opinions were sought concerning training programs for mental health professionals, inpatient, day patient, outpatient and follow-up services, occupational training opportunities, housing, case management and crisis services, and availability of community based rehabilitative and recreational programs.

2. Barriers to Service

The clients that require specific services may not be receiving the services. This might arise from the unavailability of specific services, from overloading within the services, or from barriers to service such as location of the services, financial impediments or stigma. Therefore a section of the needs survey attempted to define which barriers to service, if any, existed and to obtain an estimate of the significance the respondents attached to the barriers to service that do exist.

Barriers might exist because of an inadequate knowledge base due to insufficient research or inadequate dissemination of the knowledge. Possibly knowledge is not the problem at all. We know from many reports that there are major funding difficulties. How significant do our respondents consider these? To what extent are staff shortages a problem, or stigma, or

geographical impediments? Possibly a series of fairly adequate services are in place and the problem is one of coordination. Through the needs survey we attempted to clarify the opinion of the respondents on all these questions.

3. Program Needs

What areas of the service system are seen in need of the most improvement? Respondents were asked to judge for their own province the areas they saw as requiring the most input to improve the system of care for the chronically mentally ill.

4. Knowledge

A voluminous literature exists on the care of the chronically mentally ill. The preponderance of this literature deals with care of the chronically mentally ill in the community and with the advantages of community treatment as compared to hospital treatment. To what extent are the principles that are generally espoused in the literature acknowledged by the mental health professionals? Are research findings in the professional literature transmitted to program planners, administrators and front line workers or do they remain in the literature as the esoteric knowledge of academics? Are there blocks to the dissemination of knowledge along professional lines?

Through the needs survey we sought to determine how well the findings of the literature were disseminated through the professional groups. Consequently the needs survey explored the knowledge of the advantages of different types of treatment for the chronically mentally ill.

5. Values

Another factor that affects the provision of services for the chronically mentally ill are the value systems of the society, the professional disciplines and the mental health workers themselves. It has been pointed out in the literature that the community care value system is dramatically different from the institutional care value system or from the value system that concentrates on the private practice treatment of a somewhat different population (Lehman & Lehman, 1976). How do the values of the respondents toward community care or toward institutional care influence their ordering of service priorities? Is the goal of the service system to cure or is it to seek the optimum level of functioning for the client? To what extent do professional value systems or societal value systems affect the rewards within the systems of care? For example, in the U.S. literature it is often cited that financial and professional prestige rewards certainly mitigate against working with the chronically mentally ill as a career (e.g., Lehman & Lehman, 1976; Stern & Hoover, 1980).

6. Role of Canadian Mental Health Association

What is the role of Canadian Mental Health Association in the care of the chronically mentally ill. Is its major role one of social action or one of provision of services? We wondered what the respondents felt the role of Canadian Mental Health Association should be in relation to this population.

7. Professional Roles

Finally we wondered which professions the respondents felt were best suited to the care of the chronically mentally ill and

whether their opinions were determined along discipline specific lines or by acknowledgement of specific skills common to a larger group of disciplines.

After items had been composed to acquire information in each of the above domains, the questionnaire was presented in a preliminary form to the Mental Health Services Committee of Canadian Mental Health Association where it was discussed extensively and revisions suggested. Next, the questionnaire was presented at a meeting of the Executive Directors of Canadian Mental Health Association where it was again discussed and further revisions made. The next stage in this process involved pretesting the questionnaire on several Manitoba mental health professionals.

Although it was not possible to do extensive psychometric work on this test to determine the reliability and validity of the proposed scales, it was hoped that the process of extensive consultation with both the mental health literature and mental health professionals would maximize the construct validity of this questionnaire.

3. Community Forums

A community forum was planned and held in each province. (At the time of writing the forum has not yet been held in Ontario.) People who were sent the key informant survey in each province were also invited to attend these community forums for purposes of debriefing the questionnaire and discussing the state of mental health services in their province. A member of the Canadian Mental Health Association Mental Health Services Committee attended each of these forums.

Although the format in each of these forums varied depending on circumstances in each province, the general format was as follows. At the start of the forum the Canadian Mental Health division executive director or a designate presented an overview of the provincial mental health care system for chronic mental patients. This generally led to a free flowing discussion of provincial service delivery systems. Following a discussion of provincial service delivery systems the needs survey questionnaire was discussed. This provided an opportunity for participants to clarify areas which may have been ambiguous or omitted in the standard objective questionnaire format. In each division an attempt was then made to end the meeting with consensus building and discussion of priority needs areas within that division. A recorder was appointed at each forum to keep a record of group discussion.

III. Results

A. National Symposium

A symposium on mental health services for the longer term mentally ill was held in Toronto on February 24-26, 1982 with 30 participants from across the country (see Appendix 2 for a list of participants). The participants were asked to submit brief overview statements in advance of the meeting. This report is based on a synthesis of those statements as well as the reports on the discussion groups.

1. The Nature of Chronicity

Throughout history a number of attempts have been made to provide adequately for people with chronic mental disorders whether these people were to be cared for in the institution, as for example in the era of moral treatment, or within the community as with the recent move toward deinstitutionalization. Each of these eras of concern for the chronically mentally ill was based on the highest level of humanitarian concern. However, coupled with these concerns was a covert denial of the fact of chronicity or incurability with the assertion that environmental change would remove the deleterious effects of the disorder and allow the mentally ill to be cured or at least greatly improved. In fact, in each of these movements, a large number of people with chronic mental disorders were deprived of optimal treatment. With these thoughts Dr. Leighton challenged the participants at the meeting not to deny the fact of chronicity but instead to seek ways of accepting it and working to minimize its effects.

2. Who are the Chronically Mentally Ill

Many of the participants at the meeting chose to define the chronically mentally ill by diagnosis, duration of the disorder and by

specific deficits. The major diagnoses are schizophrenia, affective disorders, organicity and severe personality disorder (D'Arcy; Grunberg; Toews). A slightly different grouping differentiated between the person with a chronic mental disorder who had been discharged after long-term hospitalization and had a life style of relatively stable dependency and the younger "new chronic" patient, characterized by numerous admissions to the general hospital and periods of gross social inappropriateness that repeatedly caused the individual to be extruded from their living situation back to the hospital (Hicks). That this differentiation may not be solely the result of interaction between the individuals and their environment and that the service requirements and patterns of care differ for those unremittingly ill from those who have episodic exacerbations was emphasized (Fenton).

A model was presented of the interaction of the disease with an environment that serves to elaborate a set of behaviours or areas of deficit in keeping with the sick role, and the individual's, the system's and society's expectations (Figure 1). Dr. D'Arcy stated "we have to recognize that any disability, be it physical or psychological is filtered by one's social environment. Disabilities become social handicaps as they go through a process of social construction and interpretation."

While the diagnosis is important, a number of contributors spoke of the need to clearly differentiate each individual's specific deficits. Among others these may be in areas of self care, self esteem, economic self sufficiency, independent living, expressive-receptive language skills, motivation, or the ability to experience or have available rewarding activities (Hicks; D'Arcy).

Wattie noted that recent data from a follow-up study of schizophrenic patients in four Canadian provinces indicate gender

differences in onset pattern and living conditions. Onset of the disorder appears to be greatest among young males, and schizophrenic males are more likely than schizophrenic females to be found unmarried and living in poor housing or residential care. Female patients are more likely to live with family members, including spouses, and in households with higher family incomes.

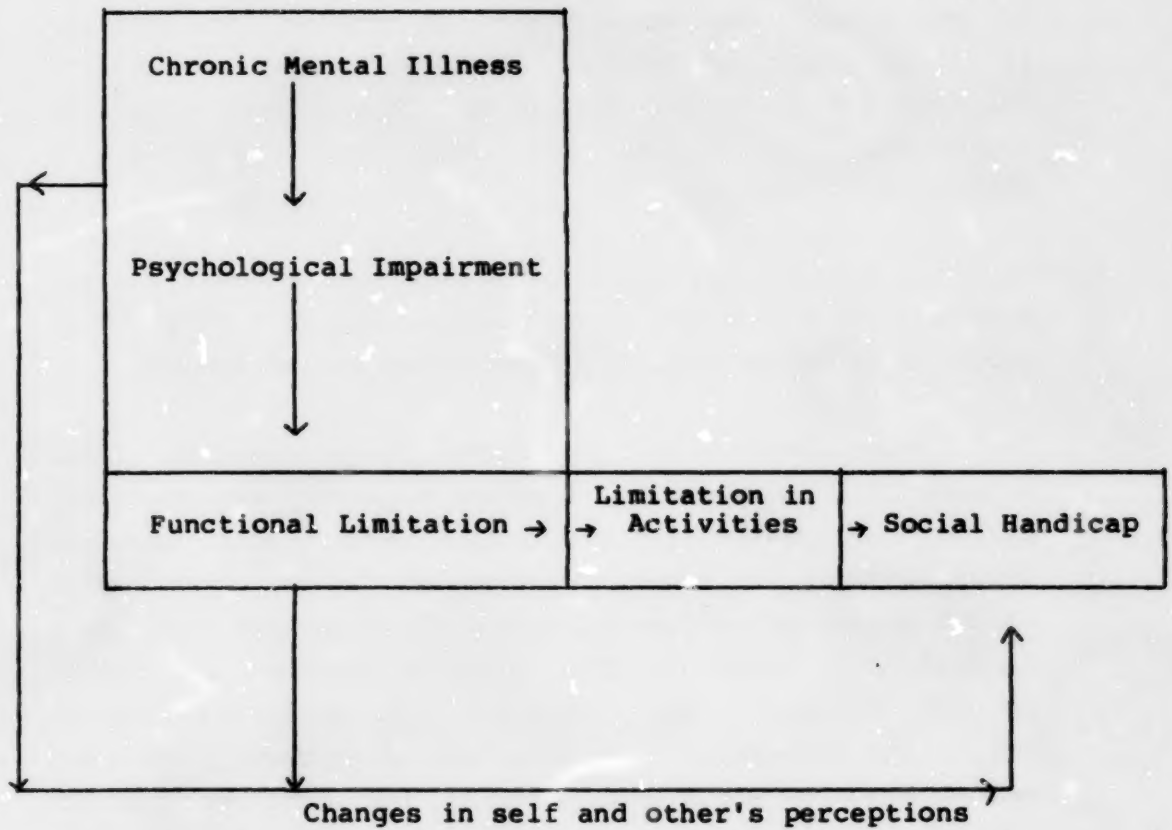
A composite definition of the chronic patient might be "the chronically mentally ill patient suffers from a mental or emotional disorder that sharply limits the ability of the individual to interact with his or her environment in such a way as to sustain oneself adequately and/or relate competently to others" (Toews).

3. How Many People with Chronic Mental Disorders are there in Canada

A number of participants addressed the numerical scope of the problem presented by the chronically mentally ill. Statistics Canada reports provide a major Canadian source of information. Unfortunately these statistics are event statistics rather than the cohort statistics which are required for giving a longitudinal view of the pattern of service inputs to any single individual.

Brenda Stoneham provided an analysis of the most recent Statistics Canada figures. There has been approximately 20% decrease in the numbers of discharges from mental and psychiatric hospitals between 1970 and 1978 (from 52,339 to 42,738 discharges) while there has been a marked increase of 89% (from 37,566 to 70,881) in discharges from psychiatric units in general hospitals during the same period. The total number of admissions to general hospitals (not designated psychiatric units) for psychiatric disorders has not increased appreciably throughout a similar period. People with a diagnosis of psychotic conditions account for approximately

FIGURE 1



52% of admissions to mental and psychiatric hospitals while accounting for 40.6% of admissions to psychiatric units. This trend is reversed for affective disorders with 16% of admissions to psychiatric units in general hospitals and 11% to mental hospitals. The length of stay for both affective disorders and psychotic conditions has decreased by 1/3 during this eight year time period. Throughout the country the number of mental hospital beds in 1978 have been reduced to approximately 1/3 of their 1970 level, some areas having a considerably greater reduction.

These statistics describe a discharge pattern generally and not chronicity per se. However, Dr. Wasylenki pointed out that 70% of admissions to psychiatric units in most studies are readmissions.

A recent analysis in the United States (Goldman, 1981) suggested that approximately 1% of the population was chronically psychiatrically disabled enough to require living in some supportive setting. Using the same percentage for Canada, approximately 200,000 people with fairly severe chronic mental illnesses exist with a diagnosis of schizophrenia, other psychotic disorders and organic disorders (Toews). Bland suggested, based on Statistics Canada and on the percentages of subjects with unsatisfactory and very satisfactory adjustment in outcome studies, that approximately 60,000 people with schizophrenia and 18,500 people with affective disorders in Canada might be termed to have unsatisfactory or worse adjustments. He further suggested that one of these is in the hospital for every four in the community. A further analysis suggested that approximately 71,320 person years were lost from the work force annually by people suffering from these disorders (Bland, 1982).

When we think of the chronically mentally ill we often think strictly of people with the diagnosis of schizophrenia. Dr. Mellor

pointed out that 40% of people diagnosed as having affective problems did not report returning to a full level of functioning after their depressions while 20% remained in a state of chronic depression over five years. Bland's figures were that approximately 15% of people with manic depressive disorders or recurrent depressive disorders had an unfavourable to very unfavourable outcome (Bland, 1982). Therefore when services for the chronically mentally ill were discussed we should also continue to be aware of the needs of people with affective disorders.

Clearly these statistics indicate that there are a large number of people with chronic mental disorders in Canada, that they represent a tremendous economic cost to society in terms of decreased productivity and that most of the chronically mentally ill reside in the community. The figures also demonstrate the shift in emphasis from the mental hospital to the general hospital system. Concern was expressed by Dr. Humphrey and echoed by others that the community system for the care of the chronically mentally ill is not adequately funded and is not at a level where it can cope with the needs of this population. The service system is becoming dramatically overloaded and adequate help is often very hard to get. He indicated that the services are now much more available to a broader base of consumers, that many more services are given to a larger number of people and that both staff resources and funding have not kept pace with the increased demand for service to this population. As a result, case loads are full to overflowing and the care given, particularly to the chronically mentally ill, is becoming increasingly diluted. This is made worse by the arrival of the post-war baby boom population at the age at risk for decompensation from psychotic episodes, and by the fact that the downturn in the economy has meant sharply limited funds and possibly even cutbacks for the service system.

4. Services for the Chronically Mentally Ill

A part of the impetus for moving people with these chronic disorders from the institution to the community was based on the belief that institutions in and of themselves contributed greatly to the social breakdown of their residents and the production of chronicity (Wasylenki). None of the participants wished a return to the institution although some, seeing the plight of the chronically mentally ill in the community, wondered for whom a therapeutic institution may not be a better alternative. However, all were committed to the concept of deinstitutionalization.

Providing there are adequate services in the community, the research to date on hospital vs. community treatment indicates that community care is superior to hospital care. Dr. Barnes (1982) reviewed the research in this field utilizing the statistical technique of probability pooling to demonstrate that patients treated in the community are admitted to hospital less often and have less total time in hospital than hospital treated groups. These changes between the two populations disappear as a service is withdrawn. The community care groups showed fewer symptoms while in the community than the hospital control groups. Dr. Barnes (1982) also noted that, at least in the studies reviewed, the burden on families who care for relatives at home did not appear significantly greater. Those treated in the community may function better at work and may express greater satisfaction with their life situation. The cost of community treatment may in the long run be less expensive than hospital treatment as well. He concluded, "In short, any gains that are made in the condition of chronic mental patients, or patients with serious psychiatric disorders who have not yet been classified as chronic are hard won and easily lost. Gains are only achieved in areas where program input is extensive and are lost once this input is withdrawn. If programs do not aim directly for a particular outcome,

such as improved employment or improved social functioning, no gains are achieved in these areas." (Barnes, 1982).

Ridgely, a staff member of the Mental Health Association in the United States, pointed out that despite the dramatic difficulties noted currently in the plight of the mentally ill, deinstitutionalization was not a bad policy. The problem is that the community base was never developed to allow it to proceed in a way that therapeutic benefits could be realized. The General Accounting Office of the United States government in 1977 defined deinstitutionalization as a three fold process: "1) preventing unnecessary admission to and retention in institutions; 2) finding and developing appropriate alternatives in the community for housing, treatment, training, education and rehabilitation of the mentally disabled who do not have to be in the institution, and 3) improving conditions, care and treatment for those who need additional care" (Ridgely, 1982).

These same points apply in Canada and our experience here has been no more fortunate than that in the United States. Many participants indicated how in their provinces there is a lack of clear planning for the mentally disabled. There is often a confusion of responsibility between various ministries, community boards, hospitals and community agencies. The system is also severely underfunded. What is more, some of the funds previously attached to the hospital system, with the discontinuation of parts of that system, were never returned fully to community care programs for that hospital's clientele. The closure of the Lakeshore Psychiatric Hospital in Ontario and the assertion that approximately 10% of that money was reapplied to the specific attachment area for community care was cited as an example of this (Parker).

The community care systems were seen by participants as patchy, with difficult, often unmanageable breaks between one part of

the system and another. Often the chronically mentally ill have low stress tolerance, poor motivation and various maladaptive behaviours as a result of their illness. They find that they are left on their own to negotiate for services within the system. Various methods of case management were suggested, including models where the case manager or coordinator performs a coordinating, a monitoring, an assessment, a linking and an advocacy role for the patient (Anderson, Fenton). This case management system should reach into the hospital to aid discharge planning and the transition from hospital and any other community service transitions that may be required (Wasylenki). The case management system should recognize the fact that the commitment to the chronically ill client is for a lengthy time (for some a minimum of two years, for others a lifetime). The contact must be designed to vary in intensity from infrequent and casual contact during periods when the client is managing well to intensive contact and support when the client is facing severe stress or is in danger of decompensation (Anderson). A number of participants stated that it is time to leave the model that suggests a curative goal and concentrate instead on aiding the development and maintenance of optimum levels of functioning.

Specific barriers to service exist. A number of participants mentioned societal attitudes, stigma and community acceptance of the chronically mentally disabled as problems. Others noted resource cutbacks and chronic underfunding of the health care system, and that funds go disproportionately to hospital services rather than community services. The participants felt as well that the professional reward systems do not value service toward the chronically mentally ill.

In Canada, geography is a particular barrier to service. Dr. T. Miller described differences between rural and urban programs and noted that frequently an urban model is tried and fails

since it is inappropriate in a rural setting. Rural services are not as developed as urban services. The process of depopulation of particular age groups of the rural society with the young leaving for the city and leaving children and older people within the rural areas was mentioned as a potential problem. The process of deinstitutionalization has returned people who have been extruded in the past from smaller towns to the institution, back to the towns where again they are ostracized. The model of case management that seems to work best in the rural area is that of the regional case worker who is attached to an institutional base but works within the local communities utilizing, wherever possible, local hospital medical staff and community rehabilitative resources for the client.

Housing for the chronically mentally ill is another area where severe problems exist. Within the larger urban centres, ghettos are forming in close relationship to specific mental hospitals (Humphrey). Dr. Michael Dear, a social geographer, cautioned against the too rapid condemnation of the ghetto noting that in a sense within the ghetto there may be a concentration of available housing, resources and most importantly, a sense of community for the client. He urged instead a careful study of the phenomena of ghettoization to determine the needs that are met within that environment and to note as well the kinds of needs that cannot be met there. He suggested planning strategies that focus instead on affordable housing of good quality and the strategies that would move toward a gradual community acceptance of the chronically mentally ill before blanket condemnation and obliteration of the ghetto occurred.

5. Characteristics of Successful Services

Throughout the meeting participants returned repeatedly to the elaboration of the characteristics of successful services. These

characteristics have been defined in the literature as:

- 1) the chronically mentally ill must be targeted as top priority in care as they do not fare well in programs where there are less impaired clients absorbing staff time.
- 2) there must be linkage with other resources.
- 3) there must be a full range of services to supplement services that were traditionally carried out in hospital settings.
- 4) treatment must be tailored individually. A case management model and a 24 hour crisis intervention service are essential.
- 5) the services must be culturally relevant and specific.
- 6) staff must be specifically trained in the care of the chronically mentally ill.
- 7) there must be a readily available hospital liaison.
- 8) there must be internal service evaluation.

(Ridgely, 1982).

At the level of service organization, the Greater Vancouver Mental Health Service was presented as a service delivery model which meets the eight criteria cited by Ridgely. Here the importance of a clear mandate from the Ministry of Health to provide direct treatment and community care from decentralized locations to the chronically mentally ill on a priority basis is considered essential and the role of advocacy both at the client and at the program level is stressed. Within the Ministry of Health, this organization

actively promotes the support and funding of those programs and services under public and as well as non-profit auspices which are needed to maintain the mentally ill in the community. They work in a coordinated and complementary way with non-profit organizations involved in such functions as housing, sheltered employment and social recreational programs for the mentally ill at both the planning and direct service level. These components of the system can seek funds from a large spectrum of funding sources and engage in an active public lobby. Thus the Service operates as the interface between the public and non-profit systems and the hospital and community systems (Hicks).

6. Recommendations

The participants in the meeting on the longer term mentally ill posed a series of recommendations within their presentations.

1. The resources for treating acute exacerbations of a chronic disorder are different from those required to ameliorate the long term chronic disabilities. Therefore, we require acute care services but in addition we require viable, long-term rehabilitation services (Fenton).
2. We must recognize the potential limitations placed on the chronically ill by their disease process. The goal should be to help people obtain their optimum level of functioning within a comfortable non-hospital environment rather than focusing on the elusive goal of care and complete social reintegration (Grunberg).

3. The services must be prepared for lifelong service, and have the capability and flexibility of responding to the level of involvement that the client requires at that particular time. As mentioned earlier the case manager approach is likely the most helpful (Grunberg, Anderson).
4. In keeping with the rehabilitation model the assessment of clients should include an assessment of living skills, strengths and deficits. Specific life skills training and long-term work programs are required. It is unrealistic to expect that the chronically mentally ill will gain competitive employment (Anderson; D'Arcy).
5. There should be a more comprehensive range of structured and semi-structured housing.
6. There should be a comprehensive range of day and evening programming including comprehensive leisure and recreation programming (D'Arcy).
7. The financial resources necessary for a life of dignity are required for the clients.
8. There is a need for basic science research to determine modifiable causes of the chronic mental disorders. Epidemiological studies and studies into specific measures of disability are also required. As a base to the epidemiologic study there is a need for a national data collection system, not just of hospital based event statistics, but of cohort statistics that note patterns of care within the whole of the system of care for people with longer term mental disorders (Fenton; D'Arcy; Grunberg; Miller).

9. A reassessment of the funding for the mental health care system is required. Are the funds going to where they are most needed and most effectively used? After that reassessment it is likely that additional funds for specific services will be required.
10. Clear governmental and administrative responsibility for services for this population must be defined.
11. There is the need for specific professional educational courses designed to train people specifically for working with those who are chronically ill. Currently most professional schools do not teach this.
12. An aggressive campaign of public education and advocacy is urgently required. Volunteer programs should be developed. These programs should be aimed at increasing public awareness of the needs of the chronically mentally ill and of decreasing the stigma attached to these disorders. The advocacy stance was seen by participants as the only way of eventually bringing about a major change in the system for providing services to the chronically mentally ill. The Canadian Mental Health Association was seen as the major contributor to this area.

The seriousness with which the participants evaluated the deficits within the service system and the urgent requirement for services is highlighted in this statement "To withdraw effective programming from these patients can be compared to withdrawing insulin from the diabetic on the basis that it is too expensive" (Anderson).

B. Key Informant Survey

1. Composition of Sample

Examination of the demographic and work setting characteristics of the sample showed that the sample was divided fairly evenly by sex (male = 50.2%, female = 49.8%). Major occupational groupings also seemed to be fairly well represented (1. nurses = 23.8%, 2. social workers = 23.8%, 3. psychiatrists = 13.3%, 4. psychologists = 12.9%). The sample also seemed to be comprised of people from a variety of work settings (1. general hospital = 17.4%, 2. community mental health system = 33.8%, 3. psychiatric hospital = 19.4%).

2. Satisfaction with Services

Respondents in this survey were asked to rate the availability of 15 services in their regions on four-point scales (1 = very unsatisfactory to 4 = very satisfactory). In general most services were judged to be at the low end of the availability scale. Services which were judged to be least readily available at a national level included:

- 1) sheltered occupational opportunities,
- 2) housing resources,
- 3) social and recreational outlets.

Services which were judged to be most readily available included:

- 1) outpatient services,
- 2) inpatient beds in mental hospital,
- 3) case management services,
- 4) inpatient beds in general hospital.

Respondents were also asked to rate the quality of 13 services on a four-point rating scale (1 = very unsatisfactory to 4 = very satisfactory). Once again the services were rated fairly low. Services that were rated the lowest in quality at a national level included:

- 1) housing,
- 2) data on number and type of chronic mental patients,
- 3) sheltered occupational opportunities.

Although the provinces differed on individual items pertaining to the availability and quality of services in their region, there were no overall regional differences in the perceived availability and quality of services. In other words, no one region was uniformly good or bad. Each region seemed to have particular strengths and weaknesses.

Multivariate data analyses were employed to determine the effects of demographic factors, work setting characteristics and discipline on satisfaction ratings. Results of these analyses showed that there were no differences by work setting or discipline in rating services. Females generally rated services less satisfactory than males. These results suggest that increasing the representation of any particular group in this study (such as psychiatrists), or region (such as Ontario) would not have affected the overall results.

3. Service Barriers

Respondents in this survey were asked to rate the importance of 12 possible service barriers on four-point scales (1 = very unimportant to 4 = very important). At a national level the service barriers which were judged to be most important were:

- 1) inadequate funding,
- 2) lack of integrated community support and care programs,
- 3) poor coordination of available resources,
- 4) negative public attitudes toward people with chronic mental disorders.

4. Program Needs

In the questionnaire respondents were asked to rate 19 service areas on three-point scales (1 = do not need improvement to 3 = need a lot of improvement) according to how much need for improvement was required in these areas. At a national level the program areas which were judged to be most in need of improvement included:

- 1) community living arrangements,
- 2) sheltered occupational opportunities,
- 3) aftercare and follow-up services.

5. Knowledge

The questionnaire contained 16 items assessing knowledge in the field of management of chronic mental disorders. In the national sample the mean score on this test was 66%. Errors most frequently made on this test were in the direction of over enthusiastic support for the success of the community oriented approach. These results suggest that lack of knowledge is likely not an important factor in limiting the development of a community based system of care for chronic mental patients.

Multivariate data analyses revealed that knowledge did not vary by discipline, work setting or demographic factors.

6. Professional Values

Professional values were assessed through a series of items designed to measure community vs. traditional hospital orientation. A six item scale measuring community vs. traditional hospital orientation was constructed based on a factor analysis of these items. On this scale the overall sample scored toward the community orientation end of the scale. Multivariate data analyses revealed that values did not differ by demographic characteristics, discipline or work setting.

7. Role of Canadian Mental Health Association

Respondents were asked to rate the importance of seven possible roles for Canadian Mental Health Association on four-point scales (1 = very unimportant to 4 = very important). At a national level the roles that were judged to be the most important for Canadian Mental Health Association included:

- 1) social action,
- 2) public education,
- 3) client advocacy.

8. Professional Roles

In the questionnaire respondents were asked to judge how suitable (1 = very unsuited to 4 = very suited) individuals representing each mental health profession would be to act in the role of either case managers or consultants in the treatment of chronic mental patients. In general, all professions were rated as being well suited to these tasks, with social workers and nurses rated as being most suited to act as case managers, and psychiatrists most suited to act as consultants.

C. Provincial Consultations on the Care of the Longer Term Mentally Ill

Consultation meetings with the respondents to the needs assessment survey were held in each province. (Note: reports from Ontario and Quebec were not available at the time this report was written.) In this section we will describe the concerns expressed at the consultations and note, where appropriate, specific observations that carry significance for the service system for the chronically mentally ill throughout the country.

"Services in our province are not particularly attractive at this time. However, we feel we know what is needed. There seems to be a government commitment to change!" - participant in New Brunswick.

"We don't have an integrated coordinated mental health care system". "So my clients don't stay in group homes because they are hungry, some can be considered adequate but not nearly enough. We are not paying people enough. I don't see coloured TV's and Cadillacs in the homes of the care givers. They're not getting rich on it."

"The social assistance program should be in there - should be working with us and not against us. The systems work toward having our clients not show initiative." - participants in Manitoba.

"The way we provide mental health services to this population does not provide for a sense of dignity in one's life." - participant in Saskatchewan.

These statements catch the tone of the provincial consultations very well. The participants contributed with real intensity and candor. They were not there to passively accept the current system, or to view it too negatively. They cared passionately about what they saw concerning the plight of people with chronic mental disorders and they

were looking for any forum in which to promote the needs of their clients.

1. Organization of Services

Almost every group started by reviewing the governmental superstructure responsible for the provision of services for the chronically mentally ill. In most provinces at least two ministries deal with aspects of the programming for this population. The Ministry of Health remains responsible for the traditional medical and hospital services and for some of the rehabilitative services while the Ministry of Community Affairs or some analogous ministry administers other community rehabilitation programs, housing and often disability or social allowances. The division of the services between these two Ministries in itself did not appear to be a problem. However, in all instances the participants felt that there is little if any coordination of the planning between the two Ministries. The mental health care system was in competition with other program areas for funding. This was particularly noted in the competition, often within the same Ministry, between mental retardation services and mental health services for the same funding. At a local level, particularly in smaller communities, this division of responsibility by program and Ministry becomes less significant since there is room for informal collaboration. However, in the larger centres, the lack of coordination at the top level of the administration of the service system in the more complex and specialized service functions was strongly felt.

The participants also noted that since services for the chronically mentally ill have been divided between two Ministries, and since a shift in the emphasis of the provision of services from the provincial hospital base to a community base has occurred, the position of the Director of Psychiatric or Mental Health Services has

lost much of its influence. Initially, when the major share of mental health care was provided by the Ministry of Health, in most provinces the Director of Mental Health Service position was at an Assistant Deputy Minister (ADM) or even Deputy Minister level. While certain disadvantages may have come about from having a single Director of Mental Health Services with considerable power influencing the system, it at least allowed for integration of the limited service possibilities available at that time. Now in many of the provinces this position is considerably below the ADM level and therefore within the Ministry of Health itself takes a lower profile. As well, the sphere of influence of the Director of Mental Health Services is considerably lessened because other ministries are also involved in the provision of care for this population. Participants in the consultations felt that this shift of influence might be successful providing a coordinating mechanism for the service systems was in place and providing that there were clear lines of responsibility for whomever was responsible for different aspects of the mental health care system and for their coordination with different components of the service system. In at least five of the provinces reporting, it was felt that the coordination and responsibility for mental health services was inadequate.

2. The Hospital System

Participants in all provincial consultations noted the shift of the burden of care for the chronically mentally ill from the mental hospital system to the general hospitals. Certain exceptions exist. In Alberta all committed patients must be treated in a provincial hospital. In Newfoundland, and to a lesser extent in New Brunswick, provincial hospitals play major roles or dominate the service system. However, even in the provinces where the mental hospitals have become institutions for only the most severely debilitated and therefore have a smaller census, the mental hospital

absorbs a disproportionately large and often the largest proportion of the mental health care budget. A concern was expressed in a number of provinces that have had reductions in the census of the provincial hospitals that not all of the costs thus saved have been passed on to identifiable programs for the patients that were traditionally served by the hospital. In British Columbia the concern was raised that the community did not currently have resources for those requiring help, yet another 500 discharges of long stay patients from Riverview was projected. In Newfoundland we heard that the institutional tone of the mental hospitals permeated the mental health care system for the chronically ill and in Manitoba, in the forensic area, we heard "we get the psychotic people who have committed crimes of violence, after being discharged after a lengthy period in the mental hospital. I'm fed up with them. I want them institutionalized."

Almost all participants expressed the preference for community care and have worked very hard to support it. However, when the community system becomes jammed and cannot function many participants state they still depend on the institution in order to provide a place of asylum in the absence of other services. The plea was that even though some still require long-term hospitalization in a mental hospital, that these people be treated in smaller units, preferably within their own geographic area. Participants did not state that these units must or should be the general hospital psychiatric units since often these are inadequate for this population. Instead units specifically designed for the intensive treatment of this group may be required.

The general hospital system was seen as the major hospital backup to the community mental health care system. Here, however, participants almost uniformly reported high occupancy rates so that it was difficult to get an admission when required. Those familiar

with the hospitals pointed to an increased acuity of the kinds of problems dealt with within the general hospitals. Many participants spoke of difficulties at the hospital/community interface with a lack of adequate discharge planning within the hospital and the various community resources to meet the needs of the client as major problems leading to the deleterious effects of the revolving door system.

While many participants spoke of day patient services, most claimed that these services were not present in sufficient numbers. One participant stated "we haven't been creative at all in our use of partial hospitalization. We haven't given various forms of partial hospitalization a chance."

In at least three provinces forensic issues were discussed as urgent concerns. In Manitoba and Alberta there was the concern that when hospital beds are full, mentally ill people are treated as forensic patients after having committed a fairly minor offense almost as a means of entering into the service system. In British Columbia the concern was expressed that there are often additional demands on the already overburdened mental health care system in that often bad or illegal behaviour is seen by law enforcement officers as a reason for obtaining a psychiatric screening or assessment and that this too may create some difficulties in overloading the system. Clearly the provision of adequate service in the forensic area remains a problem.

3. Community Mental Health Services

The primary concern, expressed in every province where a forum was held, was that there are an inadequate number of spaces in community housing available to the chronically mentally ill and while certain proprietors are sophisticated in providing a supportive

environment for the residents, many are woefully ignorant of methods of support and rehabilitation, prizing a quiet, regressed client as the hallmark of a good resident. In British Columbia and Alberta the property boom and the population increase caused the disappearance from use of many of the older homes that had been available for the chronically mentally ill in the past. In Alberta many of these older homes are not available and there has been difficulty keeping pace with the growing population. In other provinces payment of operators is so low that it discourages potential proprietors from entering this service area. Another concern that was often expressed is that the size of the groups within these homes is often too large - for example, in Prince Edward Island and Ontario as many as 30 residents in one home are noted. It was felt that there should be more support and education available to the proprietors of the homes. It was also felt that there were insufficient numbers of supervised halfway houses available to the group of chronically ill clients who required more supportive care and supervision. In a number of provinces, Canadian Mental Health Association, as well as other community groups, have become involved in the provision of housing. In Alberta, by pooling the disability allowances that each of the group of patients received it was possible to obtain financing from a bank to provide a residence for these individuals. While innovative models for the provision of housing exist in most provinces, no province has enough residential opportunities.

Another universal concern was the availability of recreational programs, life skills programs and employment preparation centres. It was pointed out that with high unemployment in most regions of the country the people with chronic mental disorders might never gain employment. Participants in the consultations therefore wondered about creative use of leisure time, socialization programs, and sheltered employment programs that would provide a long-term

productive opportunity for the participant. Again, a grossly inadequate number of these programs exists.

In many provinces, disability workshops are mixed and the mentally retarded and physically handicapped compete for space with the mentally ill. Each group of people with disabilities have specific requirements that are often quite different so that often the people with longer term disabilities do not find their needs met. In other provinces the entrance level to work preparation programs is so high and the production orientation so pronounced that many people with these longer term disorders are not able to cope with the stress of entry into the programs and therefore drop out quickly and are lost to this form of rehabilitation.

There appears to be tremendous regional disparity in the financial support available to the chronically mentally ill. For example, in Alberta the participants in the forum felt the disability pension of \$530 a month was adequate while in New Brunswick the disability pension is \$300 a month if the patient is anticipated to be disabled for more than a year, otherwise it is \$100 a month. Concern was raised by the group in New Brunswick that this is a good example of the system promoting a diagnosis of chronicity in order to maintain the level of support for this population.

In all provinces, the services for the chronically mentally ill seem to be uneven in their distribution and discontinuous in their levels of interrelationships. Certain services are available only in some regions and not in others. As well, the location of services in urban centres encourages the location of the clients within the urban centres. Coordination of services is a universal problem. Even where case management techniques are used to help bridge transitions between service areas there is often no place for clients to go!

4. Educational Issues

In all provincial consultations the participants considered educational opportunities for professionals interested in the care of the chronically mentally ill to be insufficient. Most stated that their own specific training occurred on the job and that many of the professional schools do not expose their trainees to the issues faced by this population. One comment summed it up. "Most of our psychology grads won't know a chronically ill client if they tripped over one. If they did, they wouldn't know what to do with them." Of the disciplines, psychiatry and psychiatric nursing seem unique in requiring a specific emphasis on the chronically mentally ill in their training systems.

As well, most provinces have no adequate provincially supported research and evaluation base. Alberta and Saskatchewan are unique in their emphasis in this area, and Saskatchewan's commitment to evaluation and research has produced the best analysis of shifts in the service demand and epidemiological trends available in the country. In both Alberta and Saskatchewan biomedical research is also sponsored.

5. Attitudes

A few words of caution about attitudes were also shared. One participant stated that as yet our mental health care system is terribly paternalistic and that we must be careful that we do not induce chronicity by our approach. No one is totally ill - the individual must participate in the planning of their own care and in their social functioning. The professional was seen as working to help the clients to the extent possible to help themselves through the various opportunities available.

To this end there was a great deal of concern that the needs survey and the forums were strictly professional in scope and many wished it stated that now the clients too must have their say.

Professional attitudes were also discussed. It was felt by most participants that the reward system in their profession did not support working with the chronically mentally ill and that many of the participants were working with this population out of a sense of dedication and commitment almost in opposition to the major thrust of the unspoken value system within our society and within their professions.

6. Summary

The theme that occurred repeatedly throughout the consultations is that the service system for those with longer term mental disorders is not functioning well. It is poorly coordinated, patchy in its distribution and any services available are full. The community sector of this service system is under funded. Housing and activity programs are desperately required. Because of the deficits in this system, this group of approximately 200,000 Canadians is not receiving optimal care. In fact, many are receiving grossly inadequate care with little opportunity to function optimally and with dignity.

IV. Discussion

A. National Symposium and Community Forums

There is very little need for a discussion of the provincial or national consultations except to note the congruence between the discussions and recommendations of each of those meetings with the opinions stated in reply to the key informant survey.

B. Key Informant Survey

In considering the findings of the key informant survey it should be remembered that the sample in this study was not a random sample and cannot be considered to be representative of mental health professionals in Canada as a whole. Particular care should be taken in interpreting provincial data where the samples are somewhat small. This is a particular problem for Ontario where the sample represents such a small percentage of the total number of mental health professionals. On the positive side the national sample does seem to include representation from different demographic groups, different occupational groups, regions and work settings. It should also be noted that these subject factors do not seem to play a very strong role in predicting satisfaction with service, knowledge or values. Since there seems to be a fair amount of unanimity among mental health professionals concerning what is wrong with the system and what is required it may not be too critical that a random sample was not employed in this study.

It is clear from this study that satisfaction with both the availability and quality of mental health services in Canada is very low among mental health professionals. Community support services which are so essential, given the current trend toward deinstitutionalization are rated particularly low.

Consistent with the low satisfaction ratings given community support services (e.g., housing, sheltered occupational opportunities) were the high ratings given these services in the section regarding service areas requiring improvement. The main barriers which our respondents identified as blocking improved services were inadequate funding and poor coordination of services.

It seems clear from the data in this study that there is a fair degree of consensus concerning the nature of the problem facing the Canadian mental health system. It is also clear that a lack of knowledge on the part of the Canadian mental health professionals or values that are inconsistent with community mental health goals are not important inhibiting factors.

If the major inhibiting factor in terms of providing adequate mental health services for chronic mental patients is in fact a shortage of financial resources, how can this situation be improved in times of financial restraint? Unfortunately, chronic mental patients have a low priority with government planners and politicians. Since this group is small in number and does not have a lot of political power public sympathy and support for chronic mental patients must be increased. It is in this area where Canadian Mental Health Association can make an important contribution. Our respondents saw the most important roles for Canada Mental Health Association involving social action, public education and client advocacy. At a time when more and more chronic mental patients are being released for treatment in the community, public knowledge concerning the problems faced by chronic mental patients must be increased, public support for programs must be elicited, and public involvement in the care of chronic mental patients through volunteer services etc. must be increased.

V. Recommendations

It appears from this study that the major principles of the provision of services to the chronically mentally ill are well understood by the informants. That these principles are not being applied as fully as they might is a result of:

- a) underfunding of the mental health care system,
- b) possibly a misplaced emphasis in the funding of components of the mental health care system,
- c) a failure at top governmental levels and at regional levels to organize a comprehensive coordinated service system with clearly delineated lines of responsibility,
- d) inadequate educational systems to prepare people for work with the chronically mentally ill,
- e) the continued societal disregard of the chronically mentally ill and the effects of the stigma associated with these conditions.

In order for CMHA to assist in bringing about change in this system, the following recommendations are made:

1. The Canadian Mental Health Association should intensify its historically strong advocacy stance at the national, divisional and branch levels for services for this population. This stance should include:
 - a) lobbying the various levels of governments, b) public education, and c) volunteer programs. Lobbying is required to increase the sensitivity of our elected representatives to these needs. Public education is required to sensitize the community to the needs of the chronically mentally ill and to aid in decreasing the stigma associated with this disability. Volunteer programs aid greatly in fostering community involvement in the problems and in decreasing the stigma associated with these disorders.

2. The Canadian Mental Health Association should assist its divisions in preparing specific strategies for documenting further specific needs and perspectives on the care of the longer term mentally ill on a regional (divisional) basis.
3. A specific survey of the clients', friends' and relatives' perspectives on care should be undertaken to balance and complement this particular professionally based study.
4. A study should be undertaken to document specific mental health service needs in the northern and remote areas of Canada.
5. CMHA should help in the development and testing of model administrative structures and model programs for the chronically mentally ill.
6. The development of professional educational courses on the care of the chronically mentally ill should be promoted.
7. CMHA should maintain a stance in support of additional basic and applied research into these disorders.

REFERENCES

- Andrews, F., Morgan, J., & Sonquist, J. Multiple classification analysis. Ann Arbor, Michigan: Survey Research Centre, 1967.
- Barnes, G. Deinstitutionalization of Chronic Mental Patients: A Reevaluation of Outcome Studies Presented to the CMHA Consultation on Perspectives on the care of the longer term mentally ill, Toronto, 1982.
- Bland, R. The long term mentally ill: an epidemiological perspective. Presented to the CMHA Consultation on Perspectives on the care of the longer term mentally ill. Toronto, 1982.
- Braun, P., Kochansky, G., Shapiro, R. et al. Overview: deinstitutionalization of psychiatric patients, a critical review of outcome studies. American Journal of Psychiatry. 1981, 138(6), 736-748.
- Canadian Mental Health Association. More for the Mind, Toronto, 1963.
- Fenton, F.R., Tessier, L., & Struening, E.L. A comparative trial of home and hospital psychiatric care. One-year follow-up. Archives of General Psychiatry, 1979, 36, 1073-1079.
- Goldman, H.H. Defining and counting the chronically mentally ill. Hospital and Community Psychiatry, 1981, 32(1), 21-27.
- Hogarty, G.E., Goldberg, S.C., Schooler, N.R., & Ulrich, R.F. Drug and socio-therapy in the aftercare of schizophrenic patients. Archives of General Psychiatry, 1974, 31, 603-618.
- Lehman, E.W., & Lehman, E. Psychiatrists and community mental health. Normative vs. utilitarian incentives. Journal of Health and Social Behaviour, 1976, 17, 364-375.

Marshal, J. Madness: an indictment of Ontario's mental health care system.
Ontario Public Service Employees Union. Toronto, 1982.

Milord, J.T. Human service needs assessment: three-non-epidemiological approaches. Canadian Psychological Review, 1976, 17(4), 260-269.

Rosenhan, D.L. On being sane in insane places. Science, 1973, 179, 250-258.

Statistics Canada. Mental health statistics, Vol. III, Institutional facilities, services and finances (83-205), 1978-79.

Stein, L.I., Test, M.A., & Marx, A.J. Alternative to the hospital: a controlled study. American Journal of Psychiatry, 1975, 132, 517-522.

Stern, M.S., & Hoover, J.O. The clinical work of the psychiatrists in a community mental health centre. Hospital and Community Psychiatry, 1980, 31(4), 263-265.

Supportive Housing Coalition. Community housing for consumers of mental health services in metropolitan Toronto. September, 1981.

Test, M.A., & Stein, L.I. The clinical rationale for community treatment: a review of the literature. In L.I. Stein & M.A. Test (Eds.), Alternatives to mental hospital treatment. New York: Plenum Press, 1978.

Toews, J. Mental health services in a time of restraint. Canada's Mental Health, 1980, 28, 2-4.

APPENDIX I

Members of the Mental Health Services Sub-Committee

- Dr. John Toews, Chairman of Committee, Faculty of Medicine, University of Manitoba
- Dr. Sandy McPhearson, Public Health Officer, Department of Public Health, Toronto
- Dr. Barry Humphrey, Associate Professor, Department of Psychiatry, McMaster University
- Ms. Brenda Stoneham, Mental Health Division, Health & Welfare Canada
- Mr. John Trainor, Queen Street Mental Health Centre, Toronto, Ontario
- Dr. Gordon Barnes, Department of Psychiatry, University of Manitoba
- Mr. Gordon Morwood, Program Director, Canadian Mental Health Association, National Office, Toronto

APPENDIX 2

"Perspectives on the Care of the Longer Term Mentally Ill" - National Symposium Participants

- Ms. Diana Anderson, Community Occupational Therapy Association, Toronto.
- Dr. Gordon Barnes, Department of Psychiatry, University of Manitoba, Winnipeg.
- Dr. Roger Bland, Department of Psychiatry, University of Alberta, Edmonton.
- Mr. Emmet Bradley, Community Mental Health Services, Charlottetown.
- Dr. Regina Brown, Nursing Education, McMaster University, Hamilton.
- Dr. Carl D'Arcy, University Hospital, Saskatoon
- Dr. Michael Dear, Department of Geography, McMaster University, Hamilton.
- Dr. Fred Fenton, Psychiatric Department, Montreal General Hospital, Montreal.
- Dr. Walter Goresky, Vancouver, British Columbia.
- Dr. Frédéric Grunberg, Louis H. Lafontaine Hospital, Montreal.
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- Ms. Christine Lefaiivre, Kelowna Mental Health Centre, Kelowna.
- Dr. Alexander Leighton, Department of Psychiatry, Dalhousie University, Halifax.
- Dr. Colin Lipscomb, Mental Health Clinic, Saskatoon.
- Dr. Robert Martin, University of Manitoba, Winnipeg.
- Dr. Clive Mellor, Department of Psychiatry, Memorial University, St. John's.
- Dr. Tony Miller, Sudbury Algoma Hospital, Sudbury.
- Mr. G. Morwood, CMHA, Toronto.
- Ms. Anne Louise Parker, CMHA, Ottawa.
- Ms. Norma Pickle, Fredericton, New Brunswick.

Ms. Susan Ridgely, National Association for Mental Health, Arlington, Virginia.

Dr. Mary Seeman, Clarke Institute of Psychiatry, Toronto.

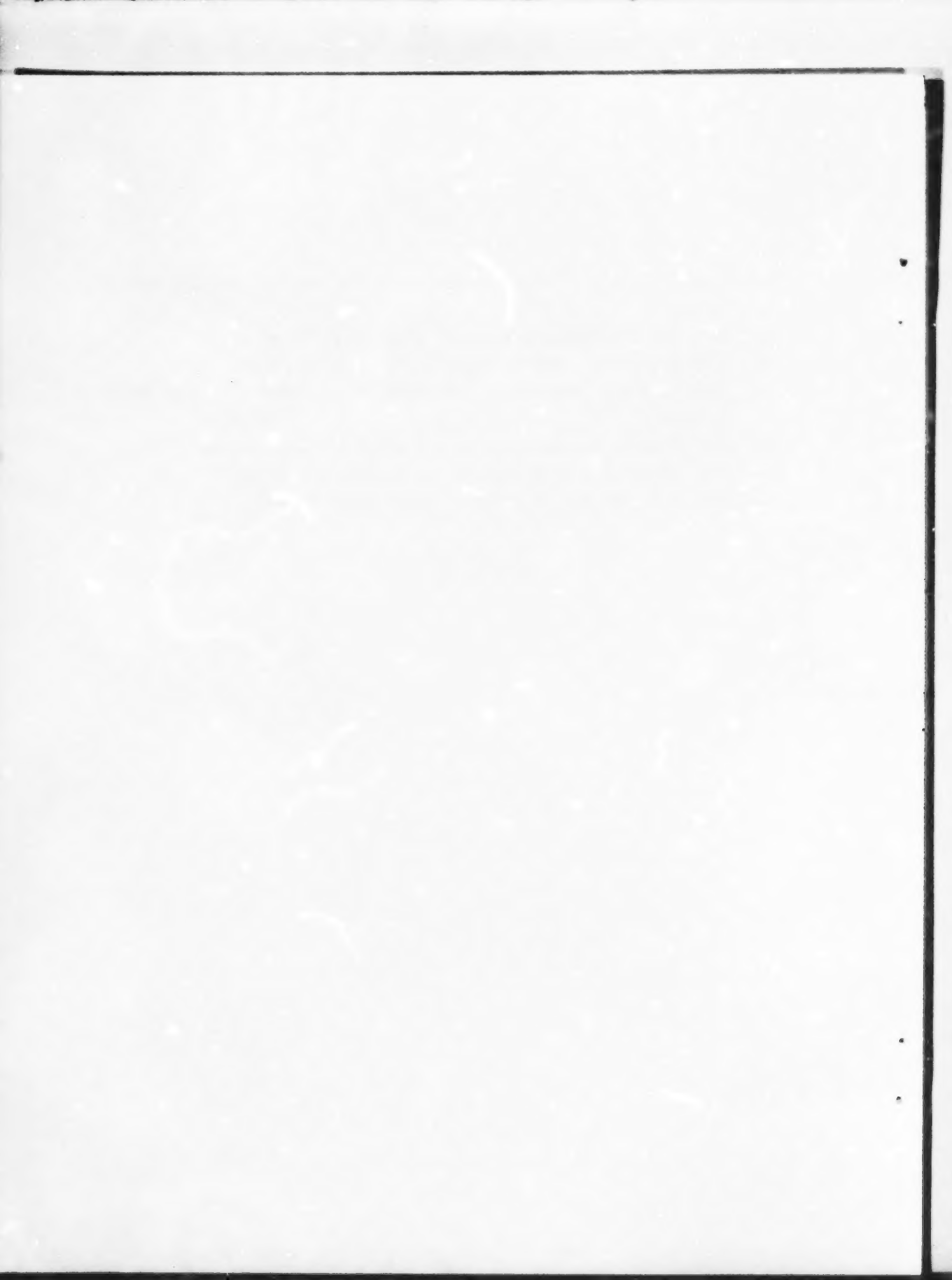
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Ms. Brenda Wattle, Mental Health Division, HWC, Ottawa.



Appendix 3 - Key Informant Survey: Questionnaire

SECTION I

Satisfaction with Current Health Services for Chronic Patients

In the following section I am going to ask you about a number of services for the chronically mentally disabled that may be available in your province. If you are not familiar enough with any of these services to rate them please omit that question. I would like to ask you to judge how satisfactory these services generally are according to the following four categories.

	Very Unsatisfactory	Unsatisfactory	Satisfactory	Very Satisfactory
	1	2	3	4
1. Availability of training programs for mental health personnel.	1	2	3	4
2. Quality of training programs for mental health personnel.	1	2	3	4
3. Quality of training programs for health care personnel generally.	1	2	3	4
4. Availability of after care and follow-up services for deinstitutionalized patients.	1	2	3	4
5. Quality of after care and follow-up services for deinstitutionalized patients.	1	2	3	4
6. Availability of sheltered occupational opportunities.	1	2	3	4
7. Quality of sheltered occupational opportunities.	1	2	3	4
8. Availability of housing resources (e.g., group homes, foster homes, etc.) for people with chronic mental disorders.	1	2	3	4
9. Quality of housing resources for people with chronic mental disorders.	1	2	3	4
10. Availability of case management services (i.e., are deinstitutionalized patients assigned to anyone).	1	2	3	4
11. Quality of case management services.	1	2	3	4
12. Availability of inpatient beds in general hospitals.	1	2	3	4
13. Availability of inpatient beds in mental hospitals.	1	2	3	4
14. Quality of care provided by inpatient services in general hospitals.	1	2	3	4
15. Quality of care provided by inpatient services in mental hospitals.	1	2	3	4
16. Availability of outpatient services.	1	2	3	4
17. Quality of care provided by outpatient services.	1	2	3	4
18. Availability of day hospital services.	1	2	3	4
19. Quality of day hospital services available.	1	2	3	4
20. Availability of statistics on number and types of chronically mentally ill patients.	1	2	3	4
21. Quality of data available on number and types of chronically mentally ill patients.	1	2	3	4
22. Availability of crisis assistance for people with chronic mental disorders.	1	2	3	4
23. Quality of crisis intervention services available.	1	2	3	4

	Very Unsatisfactory	Unsatisfactory	Satisfactory	Very Satisfactory
	1	2	3	4
24. Availability of psychosocial rehabilitation services (e.g., training in life skills).	1	2	3	4
25. Quality of psychosocial rehabilitation services that are available.	1	2	3	4
26. Extent of community involvement in care.	1	2	3	4
27. Procedures for protecting patient rights.	1	2	3	4
28. Availability of social and recreational outlets for people with chronic mental disorders.	1	2	3	4
29. Extent to which provincial government provides direction for mental health services.	1	2	3	4
30. Availability of geriatric services.	1	2	3	4
31. Availability of beds for patients suffering from chronic physical diseases or injuries.	1	2	3	4

SECTION II

Service Barriers

Below are listed a number of possible barriers to the provision of adequate services for people with chronic mental disorders. Please rate how important you think each of the following barriers are in restricting adequate services for these people.

	Very Unimportant	Unimportant	Important	Very Important
	1	2	3	4
32. Lack of sufficient research on effectiveness of various types of treatment.	1	2	3	4
33. Inadequate dissemination of existing knowledge in this field.	1	2	3	4
34. Inadequate funding levels.	1	2	3	4
35. Poor coordination of available resources.	1	2	3	4
36. Negative public attitudes toward people with chronic mental disorders.	1	2	3	4
37. Inadequate training of mental health personnel.	1	2	3	4
38. Shortage of mental health personnel.	1	2	3	4
39. Lack of precise planning goals.	1	2	3	4
40. Inadequate patient tracking (i.e., case management) systems.	1	2	3	4
41. Lack of integrated community support and care programs.	1	2	3	4
42. Geographic impediments.	1	2	3	4
43. Cultural impediments.	1	2	3	4

SECTION III

Program Needs

Below are listed a number of areas that may be important for improving health services for people with chronic mental disorders. Would you please judge whether or not you think present provisions in these areas in your province

	Do Not Need Improvement (i.e., Satisfactory)	Need Some Improvement	Need a Lot of Improvement
	1	2	3
44. Training programs for mental health personnel.	1	2	3
45. Training programs in mental health care for health personnel generally.	1	2	3
46. After care and follow-up services.	1	2	3
47. Sheltered occupational opportunities for people with chronic mental disabilities.	1	2	3
48. Alternative community living arrangements for the chronically mentally disabled.	1	2	3
49. Case management techniques.	1	2	3
50. Inpatient psychiatric services in mental hospitals.	1	2	3
51. Inpatient psychiatric services in general hospitals.	1	2	3
52. Daypatient services.	1	2	3
53. Data gathering systems on the chronically mentally ill.	1	2	3
54. Crisis intervention services for people with chronic mental disorders.	1	2	3
55. Psychosocial rehabilitation services.	1	2	3
56. Community participation in treatment of mental illness.	1	2	3
57. Safeguards for patients' rights.	1	2	3
58. Social and recreational outlets for the chronically mentally disabled.	1	2	3
59. Provincial government policy initiatives.	1	2	3
60. Geriatric services.	1	2	3
61. Services (e.g., beds, etc.) for patients suffering from chronic physical diseases and injuries.	1	2	3
62. Income assistance services for the chronically mentally disabled.	1	2	3

SECTION IV

Needs Assessment Survey - Knowledge

From your knowledge of the literature on the care of the person who has a chronic mental disorder, do you feel that these assertions are true or false?

	<u>True</u>	<u>False</u>
63. Home care has been shown to be more effective than hospital care for the non-organic, non-suicidal patient presenting to hospital for admission.	1	2
64. In alternatives to hospitalization studies, families who keep the disabled family member at home with medical and supportive care services reported significantly more burden than those whose mentally ill family members were admitted to hospital.	1	2
65. Patients kept in hospital for a longer time are less likely to return to hospital and to be admitted as compared to those who receive treatment at home.	1	2
66. Short-term hospitalization (7-10 days) for people suffering from a chronic mental disorder can be as effective as longer term hospitalization.	1	2
67. People treated in the community with a "total community living approach" functioned better than those given standard follow-up care.	1	2
68. People treated in the community with a "total community living approach" maintained their therapeutic gains when returned to regular follow-up.	1	2
69. It is less expensive (total costs considered) to keep a patient in the hospital rather than in a fully developed community care service.	1	2
70. Inpatient crisis units have been shown to decrease significantly the re-admission rate of people suffering from chronic mental disorders.	1	2
71. Daypatient units have not been shown to decrease significantly the re-admission rate of people with chronic mental disorders.	1	2
72. Maintenance of medication alone has been found to be less effective in preventing re-admission of the chronically mentally ill than sociotherapy alone.	1	2
73. Maintenance of medication has been found to be the single greatest factor in preventing re-admission of the chronically mentally ill.	1	2
74. If compliance in taking medication could be assured, relapses of people with chronic mental illnesses could be eliminated.	1	2
75. The recidivism rate is higher when clients with chronic mental disorders live in group homes rather than alone.	1	2
76. There is a positive correlation between receiving standard community after care and the prevention of re-hospitalization for clients with chronic mental disorders.	1	2
77. The de-institutionalization movement began as a result of program evaluative research that demonstrated that the chronically mentally disabled people did better living in the community.	1	2

	<u>True</u>	<u>False</u>
78. The location of residences, board and room accommodation and to the location of services for the chronically mentally disordered promote the drift of the chronically mentally disabled to the core areas of cities.	1	2

SECTION V

Needs Assessment Survey - Values

Would you indicate the degree of agreement with the following assertions which involve individual values within mental health care.

	Strongly Disagree	Disagree	Agree	Strongly Agree
	1	2	3	4
79. Mental health care systems should have primary prevention (i.e., prevention of disease by dealing with the antecedent conditions) as a major focus.	1	2	3	4
80. Mental health care systems should have tertiary prevention (minimizing the longer-term deficits of a disease process) as a major focus.	1	2	3	4
81. A goal of mental health care systems should be to serve as many people as possible.	1	2	3	4
(82.-88.) A goal of community mental health services is to identify new populations to serve:				
82. people in life crises.	1	2	3	4
83. people with personality disorders.	1	2	3	4
84. people with addictions.	1	2	3	4
85. minority groups.	1	2	3	4
86. people with major psychoses.	1	2	3	4
87. the elderly with organic mental deterioration.	1	2	3	4
88. the elderly with social deterioration and isolation.	1	2	3	4
89. The goal of community mental health services is to serve those most in need (the sickest) first.	1	2	3	4
90. Mental health professionals are more valued (rewarded) for treating less ill clients and for academic pursuits rather than for treating clients with chronic disorders.	1	2	3	4
91. The greatest professional esteem is reserved for those who work with the most difficult chronically disabled clients.	1	2	3	4
92. Within my profession the greatest financial rewards are for those who deal with the most difficult chronically mentally disordered clients.	1	2	3	4
93. My professional training equipped me to deal with the problems of the chronically mentally ill in the community.	1	2	3	4
94. The goal of therapy is to make people with chronic disorders well.	1	2	3	4

	Strongly Disagree	Disagree	Agree	Strongly Agree
	1	2	3	4
95. If a client with a chronic mental disorder is not doing well in the community, he or she should be sent to the mental hospital.	1	2	3	4
96. Mental hospitals have no more to offer the chronically mentally ill and should be closed.	1	2	3	4
97. If a person with a chronic mental disorder is not doing well in the community, he or she should be referred to a general hospital psychiatric service for an inpatient admission.	1	2	3	4
98. If the client with a chronic mental disorder is not doing well in the community, use of resources other than hospitalization will allow for improved functioning.	1	2	3	4
99. The goal of therapy is to maintain the best level of functioning in people with chronic mental disorders.	1	2	3	4
100. The client with an ongoing mental disorder should be responsible for their own contacts with the community resources.	1	2	3	4
101. The main cause of chronic mental disorder is the continuation of persistent maladaptive learned behaviour.	1	2	3	4
102. The main cause of chronic mental disorder is a disease with a biological basis.	1	2	3	4
103. The hospital care of the chronic mentally ill should be within or close to the local community.	1	2	3	4
104. The care of the chronically mentally ill is best given on a one-to-one basis.	1	2	3	4
105. The care of the chronically mentally ill is best given by a team of mental health professionals working together.	1	2	3	4
106. The local community should be able to determine its own prioritization of mental health needs and services.	1	2	3	4
107. The local community should administer its own mental health services.	1	2	3	4
108. People who are chronically mentally disabled should have a greater role in the management of their own treatment.	1	2	3	4
109. Mental health services should concentrate on secondary prevention (early identification of problems and rapid treatment) as a major focus.	1	2	3	4
110. Mental health services should be organized as an integrated system.	1	2	3	4

SECTION VI

Role of Canadian Mental Health Association (CMHA) in services for people with chronic mental disorders. Would you rate the importance of the following possible roles of CMHA.

	Very Unimportant	Unimportant	Important	Very Important
	1	2	3	4
111. CMHA should be engaged in public education in the field of chronic mental disorders (disabilities).	1	2	3	4
112. CMHA should provide direct program support through its staff and volunteers for the chronically mentally disabled.	1	2	3	4
113. CMHA should act as an advocate for the clients in their grievance with the mental health care system (ombudsman).	1	2	3	4
114. CMHA should take a social action role with community organisational funding bodies and governments to bring about changes in services for the chronically mentally disabled.	1	2	3	4
115. CMHA should concentrate its efforts on tertiary (rehabilitative) strategies with this group of people.	1	2	3	4
116. CMHA should concentrate its efforts on primary preventative and educational functions for the whole field of mental health and mental illness.	1	2	3	4
117. CMHA should direct its efforts to other mental health problems since there is already a major public investment in mental health care for this group of chronically mentally disabled.	1	2	3	4

SECTION VII

Need's Assessment Survey - Professional Roles

The next questions deal with professional roles in the care of the chronically mentally disabled.

	Very Unsited	Unsited	Sited	Very Sited
	1	2	3	4
118.-123. Which professionals by training are best suited to be case managers for the care of the client with a chronic mental disorder?				
118. psychiatrists	1	2	3	4
119. psychologists	1	2	3	4
120. nurses	1	2	3	4
121. occupational therapists	1	2	3	4
122. social workers	1	2	3	4
123. family practitioners	1	2	3	4

	Very Unsited 1	Unsited 2	Sited 3	Very Sited 4
124.-129. Which professionals are by training best suited to act in a consultant status on the care of the chronically mentally ill?				
124. psychiatrists				1 2 3 4
125. psychologists				1 2 3 4
126. nurses				1 2 3 4
127. occupational therapists				1 2 3 4
128. social workers				1 2 3 4
129. family practitioners				1 2 3 4

SECTION VIII

Demographic and Work Setting Information

Please answer the following questions on the answer sheet provided and on the questionnaire when necessary.

130. Sex:
1) male
2) female
131. Occupation:
1) nurse
2) social worker
3) psychiatrist
4) psychologist
5) occupational therapist
6) other (specify) _____
- 132.-138. Education:
Please indicate which of the following qualifications you possess.
- | | Have | Don't have |
|--|------|------------|
| 132. High school diploma | 1 | 2 |
| 133. Bachelors Degree (B.A., B.Sc., B.Sw., B.N., O.T.) | 1 | 2 |
| 134. Masters Degree (M.A., M.Sc., M.Sw.) | 1 | 2 |
| 135. Ph.D. | 1 | 2 |
| 136. R.N. or R.P.N. | 1 | 2 |
| 137. M.D. | 1 | 2 |
| 138. Medical specialty | 1 | 2 |
139. What is your present age?
(specify) _____
140. What type of work setting do you presently work in:
1) general hospital
2) community mental health care system
3) psychiatric hospital
4) other (specify) _____

141. What is the size of the community where you work:
- 1) town of less than 5,000 people
 - 2) city of 5,000 to 24,999
 - 3) city of 25,000 to 99,999
 - 4) city of 100,000 to 499,999
 - 5) city of 500,000 or more people
142. Would you say that your present job is primarily:
- 1) direct patient care
 - 2) administration
 - 3) teaching/research
 - 4) other (specify) _____
143. What percentage of your working time would you say is spent in direct patient contact:
- 1) less than 10%
 - 2) 11-25%
 - 3) 26-50%
 - 4) 51-75%
 - 5) 76-100%